DLAB-2

License No. _____

STATE OF WEST VIRGINIA
DEPARTMENT OF TRANSPORTATION
DIVISION OF MOTOR VEHICLES

Date _____

Applicant's full name: _____

Street Address _____

City _____ State _____ Date of Birth _____

REPORT ON VISUAL EXAMINATION

Distant Vision Only	Right Eye	Left Eye	Both Eyes		TEST USED
Without Glasses	/ 20/ /	/ 20/ /	/ 20/ /	COORDINATION @ 20 ft. EXO _____ ESO _____ RT. H. _____ LF. H. _____	
	/	/	/	@ 20 ft. EXO _____ ESO _____ RT. H. _____ LF. H. _____	
With Present Glasses	/ 20/ /	/ 20/ /	/ 20/ /	FUSION-DISTANCE EXCELLENT GOOD POOR NONE	TEST USED
With New Prescription	/ 20/ /	/ 20/ /	/ 20/ /	FUSION-NEAR EXCELLENT GOOD POOR NONE	TEST USED
If Possible Measure Above @ 20 Ft. If Not, Please State Dist. Used.				DEPTH PERCEPTION EXCELLENT GOOD POOR NONE	TEST USED
Fields – Horizontal Perception Rt.° Lt. ° Total°				COLOR VISION NORMAL DEFICIENT FAIL	TEST USED

EVIDENCE OF SUPPRESSION _____

To Examining Doctor:

Kindly complete this form. Please leave blank any spaces for test on which you have made no examination. If the case is peculiar, any additional comments on a separate sheet would be appreciated

IMPORTANT: For proper identification, will you please have the person whom you have examined sign the report in your presence.

Sign here: _____

Are corrective lenses needed for distant vision? _____ For near vision? _____ Is there any double vision? _____

If so, is it corrected with glasses or other treatment? _____ Any evidence of eye disease or injury? _____

If so, describe _____

Can this be corrected or compensated for? _____

Any visual difficulty in seeing in dim light or at night? _____

In your opinion, does this person have sufficient vision to operate a motor vehicle safely? _____ If yes, should there be any restrictions imposed? _____ If so, what restrictions? _____

Comments: _____

CERTIFICATON OF VISION SPECIALIST

I, _____, being licensed to practice in West Virginia, certify that I have personally examined the vision of the above named, that a true record of this examination appears on this report and that he or she signed this form in my presence.

Signature of examining doctor: _____

Business address: _____ Date: _____